Volume 1

Homelessness — Causes & Effects

The Relationship between Homelessness and the Health, Social Services and Criminal Justice Systems:

A Review of the Literature

BRITISH COLUMBIA

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Executive Summary

Volume 1 reviews and summarizes what the published literature from Canada and the U.S. says about the relationship between homelessness and the health, social services and criminal justice systems. Specifically, do homeless people tend to use these systems more than others do and if so, what are the related costs?

Conclusions

The literature demonstrates that there is a strong relationship between homelessness and the health care, social services and criminal justice systems. People who do not have safe, secure, affordable shelter have more health problems than the general population, experience social problems that may be exacerbated by their lack of shelter, and are more likely to become involved in criminal activity than the general public. This tends to result in greater use of some services by the homeless, particularly hospital emergency services, shelters and correctional institutions, in terms of frequency and length of use. Some specific sub-groups of the homeless, such as those with mental illness, are even more likely to be involved with the health care, social services and criminal justice systems.

Several published studies confirm that homeless people cause higher costs to the health care system. They use the most costly elements of the health care system more than housed people do. There are fewer studies examining the costs of homelessness for the criminal justice and socio-economic systems, although it is known that use tends to be higher.

Research confirms (though the number of studies is limited) that preventive measures are more cost-effective than the status quo. Issues arising from homelessness are more costly to deal with after the fact than if homelessness were prevented in the first place. It is essentially a problem of "pay now or pay **more** later." Studies indicate that better access to supportive housing is cost effective and far less expensive than other alternatives such as hospital beds, shelters and jails.

"Combining affordable housing with appropriate services including help in finding work has consistently succeeded in helping people get off the streets and rebuild their lives." (Daly 1996 p. 150).

Homelessness exacerbates issues associated with poverty. Studies have found that homeless people experience problems and use services more than low-income individuals who are housed. New York pediatricians familiar with the health of homeless children have identified a "homeless child syndrome" consisting of a number of illnesses and developmental problems that are more common among homeless children than others, even poverty level children.

There is growing interest in estimating the costs of homelessness. While little research was located which dealt specifically with this issue, a number of studies are currently underway (Culhane in the United States and McLaughlin in Toronto). Those studies that have been carried out show that serving homeless individuals is more costly than serving other people. Further research is needed to learn more about homeless people in Canada, their needs for services, their use of the health care, social services and criminal justice systems, and policies and programs that affect their use of these services. While the bulk of the research literature cited here is from the United States, a significant amount of research has also been undertaken in Canada, less in British Columbia.

Most studies underestimate the true costs of homelessness. This review of the literature did not include studies of the social costs of homelessness, that is, costs both to the homeless individual and to society as a whole. Rather, it concentrated on studies that estimated costs to government, which would tend to underestimate the true cost of homelessness.

1 Introduction

1.1 Background and Purpose

Homelessness is not a single problem nor does it affect people in the same way. What homeless people have in common is:

- the need for adequate housing, a secure, safe place to live and to call home; and
- the need for enough money to live on, a job or adequate social assistance.

Some homeless people also need specialized support services, short- or longer-term assistance with addiction or physical or mental health problems.

When these fundamental human needs are not met, there are severe and sometimes tragic consequences for the people affected and, as well, there are a range of negative consequences for society as a whole.

One societal impact is the additional financial cost of coping with the needs and problems associated with people while they are homeless.

The specific objectives of this review of the literature include:

- developing a greater understanding of the relationships between homelessness and the health, social services and criminal justice systems, including the experience of specific sub-groups of homeless people such as families, youth and Aboriginal people;
- identifying what is currently known about the extent of the use of the health, social services and criminal justice systems by the homeless; and
- identifying what is currently known about the financial impacts of homelessness on the health, social services and criminal justice systems as well as the methods being used to estimate these costs.

This report is the first volume in a major research initiative on homelessness in B.C. The project was initiated to fill gaps in our knowledge and understanding of the homeless situation in B.C.

The recent report of the Toronto Mayor's Homelessness Action Task Force (1999) concludes that there would be "considerable" indirect and long-term savings to the health, social services and criminal justice systems if the recommendations in the report were implemented.

These will include, for example, savings from reduced hostel use, lower welfare caseloads, and reduced demand on the health care system, not to mention improved quality of life. While we are convinced these savings are considerable, especially for the

> municipality and the Province, time has not permitted such an analysis. That said, the financial consequences of inaction will be considerable (p. xi).

The Task Force did not undertake the difficult task of quantifying the potential savings.

1.2 Limitations of the Research Literature

As this review indicates, there is a great deal of literature on many aspects of homelessness, but the cost of inaction is one area that has not been extensively researched in an empirical fashion.

One reason is that it is difficult to separate out different factors and costs and then compile them in a systematic or uniform way. It is also challenging to look at the system as a whole. Researchers may focus on the costs associated with providing one service to the homeless, as opposed to the whole bundle of health, social and criminal justice services used by the homeless on any given day or throughout the year.

Another problem is the term "homelessness" itself. It is a fluid and confusing label for a set of social problems. It involves socio-economic arrangements that exist quite apart from those troubled by them. It is a confusing term due to conceptual imprecision, fuzzy boundaries, the influence of political agendas, the heterogeneity of the homeless population, and the assumptions and attitudes of the housed population. The studies consulted for this review employ their own definitions of homelessness, but for the most part, the focus is typically people who are sleeping rough, in abandoned buildings, or in emergency shelters.

1.3 Method

This review focussed primarily on published research literature from 1990 to 1999 specifically dealing with homelessness and the health, social services and criminal justice systems. The search was confined to Canada and the United States for the most part. A French language literature search was conducted to identify relevant Canadian literature published in French. Because of the large quantity of material, the search and review focussed on recently published surveys and syntheses of the literature.

There is much published literature on the subject of homelessness and health care. For example, a Health Star search from 1990 to 1999, using the keywords "homeless persons" yielded 1,227 citations, most of which related to some aspect of health. There appears to have been a veritable explosion of literature on homelessness in 1998 and 1999, confined mostly to the medical literature. A review of the major social science databases also found a large body of literature on homelessness.

Significantly less published literature was found on the relationship between homelessness and the social services and criminal justice systems. In addition, we found only a few studies of the costs of homelessness on the health care system and very little on costs for the social services or criminal justice systems. Of note, the Report of the Mayor's Homelessness Task Force in Toronto commissioned a background report on a related topic — a cost benefit analysis of different types of shelter.

For the most part, the various studies reported in the literature refer to the homeless population housed in shelters as their unit of analysis, a subset of the absolute homeless. At least one Canadian study was based on people living in single room occupancy hotel units, considered to be relatively homeless due to poor conditions and lack of security of tenure.

The literature review is presented according to the three main service areas: health, social services and criminal justice. For each, the relationship with homelessness is investigated, followed by an examination of service use by homeless people, and finally, estimates of the costs of service use. It should be noted that the review is representative and not comprehensive. This is due to the tremendous amount of material on several of the topics being investigated.

1.4 Report and Study Organization

Section 2 of this volume reviews the literature on the relationship between health and homelessness. Social issues, socio-economic use and related costs are the subject of Section 3. Section 4 contains a review of literature on homelessness and the criminal justice system. Conclusions drawn from the literature review follow in Section 5.

This report forms Volume 1 of a larger study on homelessness–causes and effects. Volume 2 is *A Profile, Policy Review and Analysis of Homelessness in B.C.* It contains a description of B.C. emergency shelter clients, an estimate of the number of households at risk of homelessness and a comparison with other provinces. It also contains a review of relevant federal, provincial and municipal government policies and an analysis of the effects of these policies and other factors on homelessness in B.C. Volume 3 is entitled *The Costs of Homelessness in British Columbia.* It estimates the cost of homelessness to the health care, social services and criminal justice systems for a small number of homeless individuals in Vancouver. Volume 4 is the *Background Report* containing a profile of homelessness and overview of relevant policies for Ontario, Quebec and Alberta.

2 Homelessness and Health

2.1 Relationship Between Health and Homelessness

Numerous studies in Canada, the United States and Great Britain document the relationship between homelessness and health (Golden 1999, Wright et al. 1998, Connelly and Crown eds. 1994).

> "Homeless people are at much higher risk for infectious disease, premature death, acute illness, and chronic health problems than the general population. They are also at higher risk for suicide, mental health problems and drug or alcohol addiction." (Golden 1999, p. 103).

It has also been estimated in the United States that being homeless can reduce life expectancy by 20 years (Wright et al. 1998). In Canada, the situation may be less severe. One recent study has estimated that the mortality rate for homeless people may be 20 per cent to 50 per cent lower than in the United States (Hwang 2000).

The proportion of homeless people reporting themselves to be in fair or poor health is significantly higher than that reported by the general population. For example, in Los Angeles the proportion of homeless people who reported themselves to be in poor health in a 1987 study was 70 per cent greater than the proportion among low-income respondents (Wright et al. 1998). Several other local and national studies in the United States have reported that between 37 per cent and 48 per cent of homeless persons rated their own health as fair or poor compared to between 18 per cent and 21 per cent of people in the general population (Piliavin 1994). In Vancouver, 36 per cent of single room occupancy (SRO) residents reported their health as fair or poor compared to 10 per cent of Canadians who rated their health as poor or fair according to the *Canada Health Survey* (Butt 1993). Also in Vancouver, 36 per cent of street youth rated their health as poor or fair compared to 15 per cent of all youth in school (McCreary Centre Society 1994).

Reports show that homeless people face health problems similar to those faced by the general population, but at much higher rates (Kushner 1998). There are several factors that negatively affect the health of homeless people (Golden 1999, Kushner 1998, and Wright et al.1998):

- Homelessness increases a person's exposure to infectious and communicable diseases (e.g. tuberculosis);
- Homelessness is a severely stressful existence, and severe stress can trigger genetic dispositions to diseases (e.g. hypertension);
- Long periods of malnutrition can cause some chronic conditions (e.g. anemia and various degenerative bone diseases);

- There is a higher likelihood of experiencing violence or trauma on the street or in a shelter; and
- Difficult living conditions also result in poor hygiene, inadequate diets, exposure to the elements, lack of sleep and physical injuries (Kushner 1998).

In addition, there is a strong connection between homelessness and mental health. It is generally estimated that approximately one third of homeless people suffer from mental illness. The over-representation of individuals with schizophrenia and other severe mental illnesses is seen by many as the result of deinstitutionalization of psychiatric patients, which began in the 1960s (Geyer Szadkowski 1998).

The following is a description of some of the specific health issues faced by homeless people.

Mental Health Problems and Substance Misuse

There is wide variation in estimates of alcohol, drug and mental disorders among the homeless as reported by Fischer and Breakey in Springer, Mars and Dennison (1998): 2 per cent to 90 per cent for mental health problems; 4 per cent to 86 per cent for alcohol problems; and 1 per cent to 79 per cent for drug misuse. Part of the variation may be attributed to different definitions. The most commonly cited ratio is that approximately one third of the homeless population experiences mental illness (Golden 1999).

The rates of mental illness vary for different sub-groups of the homeless. An estimated 33 per cent of single men in hostels and as many as 75 per cent of single women have mental illness (Golden 1999 and Daly 1990). Data for the Toronto area confirms this. Among hostel users (n=3600), 80 per cent of adult homeless women have mental health issues, compared with 35 per cent of adult men (Springer et al. 1998). These figures are consistent with American studies that show 71 per cent of homeless women experience mental health problems compared to 52 per cent of homeless men. Major psychiatric disorders such as schizophrenia appear to be more severe among homeless women. A study in St Louis found that 33.8 per cent of women had post-traumatic stress disorder, compared with 3.2 per cent low-income housed women and 1.3 per cent of other women (Canadian Public Health Association 1997).

In some cases, mental illness predisposes people to homelessness, while in others, homelessness is a cause or trigger of mental illness. In addition, being homeless will likely increase the duration and seriousness of mental illness. At the same time, mental illness increases the likelihood of longer periods of homelessness. A longitudinal study of 1,399 homeless adults in California found that while 45.6 per cent had no medical or psychiatric illness upon becoming homeless, 9.3 per cent of these became alcohol misusers, 4.4 per cent became users of illegal drugs and 0.9 per cent were hospitalized in a psychiatric facility within 12 months (Canadian Public Health Association 1997).

The most common mental disorders are schizophrenia, affective disorders such as depression, bipolar depression and post-traumatic stress disorder, substance misuse, and personality disorders (Geyer Szadkowski 1998). The vast majority of those with mental illness also have a concurrent substance misuse disorder. Elderly homeless people have a high rate of alcohol misuse, while younger homeless people are more likely to misuse crack/cocaine and other street drugs (Geyer Szadkowski 1998).

A review of the literature undertaken as part of a profile of Toronto's homeless population (Springer et al. 1998) concluded that alcoholism is viewed as the most pervasive health problem of the homeless. It summarizes the literature on alcohol misuse as follows:

- Alcohol misuse is more prevalent among men (36 per cent to 68 per cent) than women.
- Alcoholism is found in all age groups and both sexes.
- Highest prevalence rates of misuse occurred in the 30-64 age range.
- Prevalence rates were six to seven times higher than among the general population (p. 17).

Alcoholism has other health-related implications, according to the same report:

> Among patients receiving health care at the 19 HCH programs, alcohol misusers tended to be much sicker than were other patients. They were four to seven times more likely to suffer from liver disease, twice as likely to have serious trauma, two to three times more likely to have seizure disorders or other neurological impairments (p. 17).

The report also cites research that found that alcohol misuse may be the single greatest risk factor for involvement with the criminal justice system (Fischer 1992 and Springer et al. 1998). In Canada, offender profiles indicate that 55 per cent of federal offenders reported that they were under the influence of alcohol or drugs or both on the day they committed the offence(s) for which they were incarcerated (National Crime Prevention Council — Offender Profiles, 1995).

Premature Death

It has been stated that one of the "costs of being homeless" in America is losing roughly 20 years of life expectancy (Wright et al. 1998 p. 167). Several United States studies report an average life expectancy of homeless men to be around 51 or 52 years old. Studies in San Francisco from 1985-1990 and 1990-1996 found the mean average age of death to be 41 years old for homeless individuals (Ashe et al. 1996). The primary causes of death of homeless people between 1990 and 1996 were accidental/unintentional injuries (45 per cent), natural causes (38 per cent),

homicide (10 per cent) and suicide (7 per cent). Information from the City of Toronto also shows that homeless people tend to die at a younger age on average than the general population. Kushner (1998) cites figures that show 71 per cent of homeless people who died between 1979 and 1990 were under the age of 70 years. This compares to 38 per cent in the general population City of Toronto.

In addition, based on a study of close to 9,000 men who used homeless shelters in 1995, researchers have concluded that young homeless men in Toronto are eight times more likely to die than men the same age in the general population. In the 18–24 age group, the leading causes of death were accidents, poisonings and overdoses. Between the ages of 25 and 44, homeless men were four times more likely to die than their counterparts in the general population. Leading causes are HIV, accidents, overdoses and poisonings. Homeless men between 45 and 64 were more than twice as likely to die as men in the general population, with cancer and heart disease as the main causes (Canadian Press 1999).

In Canada, a recent study led by Dr. Stephen Hwang (2000) of St. Michael's Hospital estimates that homeless men in Toronto have a 20 per cent to 50 per cent lower mortality rate than homeless men in the United States.

About 40 homeless people freeze to death each year in Ontario (Daly 1996). There is also evidence that infant mortality is very high among children born to homeless women (Canadian Public Health Association 1997).

Acute Physical Disorders

Studies in the United States have shown that the most acute ailments among homeless adults were upper respiratory infections (33 per cent), followed by traumas (25 per cent), minor skin ailments (15 per cent) and more serious skin ailments (4 per cent). The predominant acute disorders suffered by youth were respiratory infections (35 per cent), traumas (20 per cent) and minor skin disorders (20 per cent). Problems with lice and scabies, genito-urinary problems, and gastro-intestinal disorders were also common. Among homeless children, upper respiratory infections are twice as common compared to other children, skin disorders are about four times as common, gastrointestinal disorders are about three or four times as common, and ear infections nearly twice as common (Wright et al. 1998).

Injuries from trauma are among the top three or four conditions treated by those providing health care to homeless people (Wright et al. 1998). Homeless people are at a high risk because they are often victims of violent crime, such as rape, assault and robbery. Lacerations and wounds were the most common of the traumas, followed by sprains, bruises and fractures. The rate of sexual assault against homeless women is 20 times higher than that for United States women in general. One study of women in a New York shelter found that these women were 106 times more likely to be raped, 42 times more likely to be robbed and 15 times more likely to be assaulted than were housed women. Homeless teens and mentally ill

persons, alcoholics and drug addicts also suffer higher than average risks of injury due to violence (Wright et al. 1998).

In Canada, it has been estimated that almost 40 per cent of homeless people are assaulted every year. Among homeless women, the annual risks of sexual assault is approximately 20 per cent (Canadian Public Health Association 1997).

Homeless people are often prone to skin diseases because they have great difficulty washing their bodies and clothes. It is common for homeless people to wear dirty clothing and ill-fitting shoes, and to suffer from cuts and abrasions, malnourishment and bacterial infections (Daly 1990).

Chronic Physical Disorders

As many as 40 per cent of the homeless suffer from chronic problems such as heart disease, emphysema, diabetes, high blood pressure and musculoskeletal disorders. Hypertension is estimated to occur 2 to 4 times more among the homeless than the general population. A substantial number of the homeless population has multiple problems that are compounded by a lack of proper medical attention on a regular basis (Wright et al. 1998 and Daly 1990).

A survey of the homeless in Toronto reported in the *Street Health Report* showed that homeless people were at much higher risk than the general population for many chronic conditions, as noted below (Ambrosio et al. 1992).

Condition	Homeless	General Population
Emphysema/chronic bronchitis	17.8 per cent	3.6 per cent
Arthritis/rheumatism	29.8 per cent	13.4 per cent
High blood pressure	13.2 per cent	12.5 per cent
Asthma	12.2 per cent	4.6 per cent
Epilepsy	6.3 per cent	1.0 per cent
Diabetes	3.1 per cent	2.4 per cent

Homelessness is also associated with peripheral vascular disease, which is more common among men than women. Prevalence increases with age. This is the result of constant forced walking, and a tendency to sleep with legs in a dependent position. Conditions such as edema, thrombosis, cellulitis, and ulceration follow. Poor hygiene and exposure to the environment further increase the possibility of infections. In extreme cases, these conditions can result in gangrene and amputations (Wright et al. 1998).

For youth, the most common chronic disorders were eye problems, gastrointestinal disorders (ulcers, hernias, diarrhea and gastritis), ear problems, neurological impairment, and problems with dentition (Wright et al. 1998).

Pregnancy

The pregnancy rate among homeless women is high compared to other groups of women (Wright et al. 1998). Estimates have ranged from 12 per cent to 24 per cent (Bassuk and Weinreb 1993). A recent study in Toronto found that 59 per cent of a sample of street-involved women had been pregnant (Kushner 1998). Fifty per cent of homeless pregnant women in a New York sample had been pregnant four or more times (Bassuk and Weinreb 1993).

At the same time, pregnancy is associated with several risk factors, such as inadequate nutrition, excessive stress, inadequate housing and sanitation, and many medical diseases (e.g. genito-urinary tract infections and hypertension). Pregnant women also have elevated rates of alcohol, drug and alcohol misuse. These factors lead to a higher proportion of infants with low birth weights, and much higher rates of infant mortality. Of the pregnant women in the Toronto study, almost one third experienced miscarriage, 23 per cent had pre-term babies, and 13 per cent died after giving birth (Kushner 1998 and Wright et al. 1998).

A study of homeless women in the east end of London, England found that 25 per cent of babies born to mothers who had moved into bed and breakfast hotels during pregnancy had low birth weights, compared to 10 per cent of babies born to local area resident mothers and about 7.2 per cent of babies born nation wide. This is significant not only because of the relation between low birth weight and infant mortality, but because studies have shown that there are several medical and neurological hazards of low birth weight that can put children at risk of improper development and physical and mental health problems (Connelly and Crown eds. 1994, and National Crime Prevention Council 1995).

HIV and AIDS

Studies show that infection of HIV and AIDS among homeless persons is higher than the general population (Canadian Public Health Association 1997). One study in New York found that HIV is prevalent in 15 per cent of the inner city homeless population, mostly among the high-risk group of substance misusers (Geyer Szadowski 1998). Homelessness is being seen as contributing to the spread of HIV/AIDS (Kushner 1998) and the spread of this disease among homeless people has some health professionals concerned about the possibility of an epidemic. This is the situation in Vancouver, which has identified an HIV/AIDS epidemic, particularly in the Downtown Eastside. The disease is spreading most quickly amongst individuals who are, or who are likely to become homeless and involved in injection drug use (HIV/AIDS and Injection Drug Use in the DTES 1997).

Tuberculosis

Since the 1980s, there has been a slower rate of the decline of TB infection in the United States, and there is evidence that the incidence of TB is increasing. The number of reported cases increased by 20 per cent between 1985 and 1990, and 1990 saw the largest annual increase since 1953 (Connelly and Crown eds. 1994 and Daly 1996). Studies have estimated the rate of TB infection among homeless people ranges from at least 25 times higher than the rate in the general urban population to a hundred times greater than the average for the general population (Daly 1996 and Wright et al. 1998). TB seems to be emerging as a substantial public health issue in Canadian cities as well (Canadian Public Health Association 1997). A survey of TB skin test results among homeless people in Toronto found that 48 per cent had positive skin tests (Kushner 1998). TB infection is highly transmissible, and this is compounded by the spread of HIV, which makes infected individuals even more susceptible to TB infection.

Homelessness is also being seen as a contributor to the development of treatment resistant tuberculosis (Kushner 1998). Studies show that as many as a third of patients with TB do not complete their treatment.

Dental Problems

Poor dentition is also a significant problem for homeless people. Homeless people cannot easily get basic dental care. They do not visit dentists very often, mostly because of the costs (Golden 1999 and Wright et al. 1998). Research shows that homeless adults have a higher degree of dental disease and more need for treatment due to infection, pain, and decayed teeth than the general population (Wright et al. 1998). In addition, a survey of 124 homeless people in Vancouver found that 58 per cent had a current dental problem requiring attention from a dentist (Canadian Public Health 1997, citing Acorn 1993). Poor dentition is more than 10 times as common among homeless children compared with other children (Wright et al. 1998).

Nutritional Disorders

Malnourishment is a fact of life for the homeless, which places them at risk of intestinal disorders and infectious diseases (Daly 1990). It is very difficult for them to obtain fresh fruits and vegetables. A study of homeless men at a Birmingham, Alabama soup kitchen found that 94 per cent suffered from lack of nutrients, resulting in weakness, fatigue, depression and other emotional problems (Daly 1990).

Sleep Deprivation

Life in shelters and many insecure accommodations is noisy, chaotic, anxiety producing, and often violent. Residents are usually required to leave the premises each morning. Many homeless people suffer from sleep disorders that result in apathy or behavioural impairment. Children, in particular, are likely to experience emotional difficulty and inability to function effectively in school (Daly 1990).

2.2 *Health, Homelessness and Children*

Studies in the United States estimate that families with children account for more than one third of the overall homeless population (Weinreb et al. 1998a). In Canada, the Canadian Council on Social Development in 1987 estimated that 11.5 per cent of the homeless population were children aged 15 and under (Begin 1996). In 1996, it was found that children represented 19 per cent of the total number of people using shelters in Toronto (Kushner 1998).

One study in Seattle showed that the proportion of homeless children whose health was described as fair or poor was four times higher than in the general United States pediatric population. Mothers of homeless children are also significantly more likely to report that their children are in fair or poor health (11.6 per cent) compared to other children (5.7 per cent) (Weinreb 1998). A study of 293 homeless children in shelters and welfare hotels in Massachusetts, found that homeless children were reported to have more fevers, ear infections, diarrhea, and bronchitis or asthma compared to other low income children. "Half of the homeless children compared with approximately one third of the housed children were reported to have two or more acute illness symptoms during the past month." (Weinreb et al. 1998a).

Homeless children face particular health risks compared with children who have permanent homes. These include immunization delays, asthma, ear infections, diarrhea, anemia and overall poor health (Canadian Public Health Association 1997 and Wright et al. 1998). Specific health concerns are noted below:

- Upper respiratory infectionsare twice as common among homeless children compared to other children.
- Skin disorders — are about four times as common compared to other children.
- Gastrointestinal disorders — are about three or four times as common compared to other children.
- Ear infections — are nearly twice as common compared to other children.
- Poor dentition — is more than 10 times as common compared to other children.
- Obesity — is approximately six times more prevalent among homeless children, according to a study in Washington State.
- Anemia — children living in shelters in Kansas City were noted to be receiving less than 50 per cent of the recommended daily allowance of iron and folic acid.
- Injuries and burns — in a Philadelphia sample, 14 per cent had been burned sufficiently to produce a scar and 8 per cent had been hospitalized because of injury during the previous year.
- Homeless children also typically suffer from chronic respiratory problems (Davey 1998).

Pediatricians affiliated with the New York City Children's Health Project have identified a "homeless child syndrome," which includes poverty-related health problems, immunization delays, untreated or under-treated acute and chronic illnesses, unrecognized disorders, school, behavioural and psychological problems, child abuse and neglect." (Wright et al. 1998 p. 158). Not all homeless children exhibit all aspects of this syndrome. However, most homeless children exhibit one or more of these problems and, they are more common among homeless children than among children in the general population or even poverty-level children.

Some of the reasons cited for the poor health status of the homeless children include their exposure to specific conditions in shelters (e.g. overcrowding, shared food preparation and increased risk of transmitting contagious illnesses). Another factor is the instability and distress they have experienced in the period before moving to the shelter. The homeless children were more likely to have moved in the past year, and a significant number had been in foster care or been investigated by socio-economic agencies for potential neglect (Weinreb et al 1998a).

2.3 Health, Homelessness and Youth

As with the rest of the homeless population, homeless youth also suffer from poor hygiene, inadequate diet and exposure to the elements. However, because they are younger and still growing, they are more vulnerable to these deprivations and to the violence, drugs, alcohol, sexually transmitted diseases and mental-health problems that "pervade their world." (Lowry 1996). There is also evidence, of premature death among homeless youth (Regie regional de la santé et de services sociaux de Montreal Centre 1998 and Canadian Press 1999).

A Montreal study focussed on a group of young persons (14–25 year olds) who had been without a place to sleep at least once or who had regularly made use of street youth resources over a two year period. Questionnaires were issued every six months over this period. 517 youth were recruited (72 per cent male, average age 20 years). By August 1998, 479 youth had completed at least one follow-up questionnaire. Thirteen of the youth had died (11 males and two females), which is a mortality rate 13 times higher than Quebec youth of the same age. Causes of death included suicide and drug overdose. Sixty-three per cent of respondents had had thoughts of suicide and 35 per cent had attempted suicide. Results also showed that 27 per cent of respondents were moderately depressed, 21 per cent were slightly depressed and 9.2 per cent were severely depressed (Regie regionale de la santé et de services sociaux de Montreal-Centre 1998). A study of Toronto street youth shows that 37 per cent of males had a history of attempted suicide, compared to 61 per cent of females. A survey of Ottawa street youth in 1992 found that 92 per cent had attempted suicide (Canadian Public Health Association 1997).

Sexually transmitted diseases are among the leading health problems faced by homeless youth (Canadian Public Health Association 1997 and Ensign 1998). An Edmonton survey of street youth and juvenile sex workers reported positive culture rates of 49 per cent for Neisseria gonorrhoeae and 83 per cent for Chlamydia trachomatis. No contraception was used by 57 per cent of those engaged in sex work and by 85 per cent of street youth. An interview of 100 Ottawa street kids age 15 to 19 found that 25 per cent had had at least four different sex partners within the last month, yet only 27 per cent of the boys and 8 per cent of the girls always used condoms. About 16 per cent of the girls were infected with chlamydia and had never been treated (Lowry 1996). Rates of HIV infection have been found to be 2–10 times higher than in other domiciled adolescent populations (Ensign 1998). It should be noted that one survey of Toronto street people under the age of 25 found that over 70 per cent had left home because of physical and/or sexual abuse (Lowry 1996).

Substance misuse is another problem. Data from the Addiction Research Centre in Toronto reported that drug use was 14 times higher among street youth than among students who had never run away from home, and that nearly 90 per cent of street youth reported either an alcohol or drug problem. Other information from Toronto found that 83 per cent of youth used cannabis during the previous year and 31 per cent had used cocaine. Twenty-eight per cent injected drugs at some point and 4 per cent had shared needles within the previous year. About half reported evidence of depression at some point during the three months before the interview and 46 per cent of females reported some form of sexual abuse (Canadian Public Health Association 1997).

A study of street youth in Vancouver found that for almost every health problem identified, the proportion of street youth with the problem was significantly higher than the proportion of youth attending school. For example, 37 per cent of female street youth reported having had a STD compared to only 2 per cent of females attending school. Differences were also noted in other health conditions such as asthma, accidental poisoning, hypoglycemia, chronic fatigue syndrome and emotional problems (McCreary Centre Society 1994).

2.4 *Health, Homelessness and Aboriginal People*

Aboriginal people make up a high percentage of the homeless population. In Toronto, it is estimated that Aboriginal people make up nearly one quarter of the street population, although they represent less than 3 per cent of the city's total population (Kushner 1998).

In addition to the Aboriginal people who are absolutely homeless, relative homelessness also causes health problems for Aboriginal people living in inadequate housing on reserve. It has been found that the incidence of TB, ear infections, upper and lower respiratory tract infections, pneumonia, gastrointestinal diseases, skin infection, cancer due to second-hand smoking and deaths due to fire is two to seven times greater in Aboriginal populations than in the rest of the Canadian population (Canadian Public Health Association 1997).

2.5 *Use of Health Care Services by the Homeless*

Primary Health Care

Homeless people are less likely than the general population to have a regular family doctor (Kushner 1998 and Weinreb 1998). In Toronto, about half the homeless people surveyed did not have a family doctor. More than half of those surveyed had gone to an emergency room in the past year, and for 20 per cent, the emergency room was used more than any other place for health care. Emergency rooms are accessible since they are generally open 24 hours a day, seven days a week, and no appointment is required (Golden 1999). Even though drop-in medical clinics are available in Toronto, most of the homeless use hospital emergency rooms for routine care (Lowry 1996). Homeless children appear to over-use emergency room services, under-use preventive health services, and have fewer dental visits compared to the general pediatric population (Weinreb 1998 and Wright et al. 1998).

Several barriers to regular (primary) health care have been noted in the literature. One doctor who has treated homeless people in downtown Toronto for over 10 years described the difficulties he faced in providing care for the homeless (Lowry 1996):

- The inability to locate patients to communicate test results means treatment cannot be provided.
- Many homeless people do not have a health-insurance card or use the wrong number — which means the doctor, lab and specialists do not get paid, and which can set limits on referrals and tests. Homeless people who do not have a health insurance card may be refused care altogether. It was noted that this is a major problem since the population at large is then faced with risks associated with untreated mental illness and infectious diseases (Frankford 1997).
- It is difficult to find specialists who will see homeless people. There are concerns that homeless people will disrupt waiting rooms.

- It is difficult to treat patients who may be incarcerated. At least 33 of 187 homeless women were in jail at some point in the past two years.
- Mental illness and psychotic conditions can get in the way of treatment. Patients may be afraid of doctors. An example is provided of a patient who had a psychotic disorder, diabetes and hypothyroidism. Her diabetes and hypothyroidism were out of control, but the doctor could not provide treatment because of the psychotic condition. When the patient found a place to live, she began taking medication for her psychotic illness. The doctor was then able to treat the other medical problems. "Once you find permanent housing for these people you can start to do something medically." (Lowry 1996 p. 1738).
- Lack of financial resources is also a barrier to proper health care if full or partial payment for services is required (e.g. dental care) (Kushner 1998).
- Homelessness may also make it difficult to follow treatment advice (e.g. filling prescriptions, following special diets, storing medication at the recommended temperature) (Kushner 1998).

The most common reasons given by homeless women as to why they did not obtain medical care in the past year include (Weinreb et al. 1998b):

- No child care;
- No transportation;
- Too busy with other things;
- Have to wait too long for appointment; and
- Depressed/not up to going.

Hospitals

Studies indicate that homeless people use hospitals as their main point of contact with the health care system. For example, in the United States, the percentage of homeless people who had been hospitalized for a physical problem in the past year ranged from 20 per cent to 30 per cent compared to 15 per cent in a national sample of adults and 18 per cent for domiciled poor persons (Piliavin et al. 1994). The following table summarizes the rate of admission to hospital, length of stay and emergency room use for both homeless and domiciled individuals as reported in the literature cited here.

Variable	Homeless	Domiciled	Study location and author
Admission to hospital	20 per cent to 30 per cent	15 per cent to 18 per cent	United States — Piliavin 1994
Admission to hospital—SRO		SRO—29 per cent Social housing—18 per cent	Canada — Dautovich 1998
Admission to hospital—children	11 per cent	5 per cent	United States — Weinreb 1998
Length of stay—SRO		SRO—15 days Social housing—nine days	Canada — Dautovich 1998
Length of stay—psychiatric	84 days	14 days	United States — Salit 1998
Length of stay	4.1 days longer than domiciled	N/A	United States — Salit 1998
Emergency	50 per cent	N/A	Canada — Golden et al. 1999
Emergency—children	38 per cent	20 per cent	United States — Weinreb 1998

A Canadian study found similar rates of hospitalization among single room occupancy (SRO) hotel residents who are often considered to be at risk of homelessness. In Vancouver's Downtown Eastside, 29 per cent of SRO residents reported hospitalization in the previous 12 months compared with 18 per cent of social housing residents. On average, people living in SROs stayed in the hospital for 15 days. People living in social housing spent an average of nine days in the hospital. Even though social housing residents perceived themselves to be less healthy than SRO residents, social housing residents used the hospital almost half as often as SRO residents, and on average, stayed for fewer days (Dautovich 1998).

A study in Massachusetts comparing health service use of homeless women and low-income housed women who are heads of households found that the homeless women used the emergency department more than the other women. In addition, they were almost twice as likely to have been hospitalized in the past year compared to the other women. The main reasons cited for hospitalization among the homeless women were gastrointestinal illness (13 per cent), respiratory illness (13 per cent), and trauma-related causes (13 per cent) (Weinreb et al. 1998b).

Another study in Massachusetts compared the use of health services by homeless children with low-income housed children. Thirty-eight per cent of the homeless children reported two or more emergency visits to the emergency department during the past year compared with 20 per cent of the housed children (Weinreb et al. 1998a). Homeless children were more likely to have been hospitalized in the past year (11 per cent) compared

with the housed children (5 per cent). They also had higher outpatient visit rates compared to the other children.

In a study of hospital admissions in New York, Salit (1998) found:

- 51.5 per cent of the admissions of homeless patients were for treatment of substance misuse (28.5 per cent) or mental illness (23 per cent), compared to 22.8 per cent of admissions for the other low-income patients.
- A disproportionate number of homeless patients were admitted for respiratory disorders, trauma, skin disorders and infections.
- For the homeless, 80.6 per cent of the admissions involved either a principal or a secondary diagnosis of substance misuse or mental illness — roughly twice the rates for the other patients.
- One third of the homeless psychiatric patients had hospital stays that ran more than a month longer than the two weeks generally required to stabilize an acutely psychotic patient. These patients stayed an average of 84 days and accounted for 69 per cent of all the days of hospitalization for psychiatric reasons among the homeless patients.
- The homeless patients stayed 4.1 days or 36 per cent longer per admission on average than the other patients. The differences were greatest for mental illness, AIDS and surgery.

Other studies suggest the reason homeless persons are more likely than the general population to be hospitalized following a visit to a clinic is that they seek medical attention only when their symptoms can no longer be ignored. By that time, they are likely to require more acute and complex treatments (Raynault et al. 1994). The author of the Vancouver study surmised that people living in social housing are more likely to see a doctor than people in the SROs and more likely to receive in-house help. Without a regular source of care, SRO residents may tend to wait until a problem becomes acute and end up more seriously ill and in the hospital for a longer period of time (Dautovich 1998).

Findings that homeless people use hospitals more than other people are consistent with other studies regarding low-income households. A study in Winnipeg found that individuals from low-income neighbourhoods are hospitalized at a much higher rate than individuals in middle-income neighbourhoods, who are hospitalized more frequently than residents of higher-income neighbourhoods (Roos and Mustard 1997). A study in Massachusetts of nearly 17,000 patients in five hospitals found that those with the lowest incomes, occupational prestige and education had hospital stays 5 per cent to 25 per cent longer than those with the highest socio-economic status. The patients of lower socio-economic status tended to be more severely ill, and probably required more resources than other patients (Epstein et al. 1990).

2.6 *Costs of Homelessness for the Health Care System*

There are a few recent studies that address the costs of homelessness to the health care system (Salit et al. 1998; Rosenheck and Seibyl 1998; Molyneux and Palmer n.d.; and Pomeroy and Dunning 1998). The additional costs homeless people place on hospital budgets was addressed in a study of homeless people in New York City (Salit 1998). Researchers compared the lengths of stay and reasons for hospital admissions among homeless and other low-income persons. They used hospital data on nearly 19,000 admissions of homeless patients and compared their diagnoses and lengths of stay with those of other low-income persons in New York City. In addition, they estimated the hospitalization costs that could then be associated with homelessness and found that the costs of the additional days per stay averaged $4,094 US for psychiatric patients, $3,370 US for patients with AIDS, and $2,414 US for all types of patients.

Longer stays were not treatment related — they were primarily due to lack of housing, particularly placement problems among homeless and psychiatric patients. Since 1991, New York public hospitals have been operating under a court order requiring them to place such patients in supportive housing at discharge. Physicians also reported delaying the discharge of homeless patients who required follow-up care knowing that their access to ambulatory care and clean environments or their compliance with treatment might be limited.

Physicians in this study also indicated that they lowered the threshold for admission for homeless patients whose medical conditions are likely to worsen if they remain in shelters or on the streets. The fact that homeless people were hospitalized disproportionately often for such conditions as respiratory and skin disorders, trauma, and infectious or parasitic diseases that often can be treated on an outpatient basis supports the above findings.

Salit (1998) suggests that better access to supportive housing for homeless people could reduce hospital stays by as many as 70 days per admission. For example, 70 days in a general hospital psychiatric unit even at the rate of $250/day US for subacute care costs $17,500 US, whereas a unit of supportive housing with social services for an entire year costs $12,500 US in New York City.

Commenting on Salit's findings, the editor notes:

> "Failure to deal with a social problem "upstream" (lack of housing, education, health insurance, substance misuse prevention) leads to added costs for resources "downstream"(police, prisons, hospital care). The downstream institutions are not only expensive, but also poorly equipped to deal with the underlying social problems. Many people conclude, therefore, that preemptively attacking the problems upstream would be both more efficient and more effective, but the pattern stubbornly persists. In the case at hand, we continue paying to put the homeless in hospital beds while not providing them with ordinary beds of their own." (Starr 1998).

Another study examined the health service use and costs for homeless and domiciled veterans in the United States. It found that the average annual cost of care for homeless veterans was 13 per cent higher than for domiciled veterans (Rosenheck and Seibyl 1998). This study surveyed all inpatients to the hospital in acute psychiatric and substance misuse units at Department of Veterans Affairs medical centres on a certain day to determine their residential status at the time of admission. Of the more than 9,000 veterans with complete survey data, 20 per cent were absolutely homeless, and an additional 15 per cent were doubled up, or relatively homeless. Homeless psychiatric and substance misuse patients had more in-patient days and higher re-admission rates than domiciled patients. This resulted in costs amounting to $27,206 US on an average annual basis for homeless veterans, compared to $24,010 US for domiciled veterans in the study, a difference of $3,196 US per year.

In the UK, a study of 107 households, comprising 525 people living in poor quality housing found that during a period of 150 days in the winter, there was an average of 2.62 illness per household. These illnesses resulted in 209 medical consultations, 183 prescriptions and 184 hospital visits on an in-patient or out-patient basis. The cost of providing these health services at 1996 prices was approximately £40,000 over the five month period, or an average of £515 per household over a full year. Researchers calculated that this was £387 more than the annual cost per household in the control group (Molyneux and Palmer n.d.).

Some Canadian researchers have estimated the relative costs of different types of shelter that may be used to house homeless people (Pomeroy and Dunning 1998). They estimated that it costs $360 per day to provide 24-hour care, professional staff, meals, an intensive level of health care and housekeeping services in a Toronto psychiatric hospital. This compares to:

- up to $43 per day for supportive housing with 24-hour staffing and mental health support; and
- $36 per day in a new non-profit apartment.

In New York City, it has been estimated that a psychiatric hospital bed costs $310 US per day compared to a permanent home and supportive services which costs $34 US per day (Daly 1996).

Studies note that when homeless mentally ill adults are provided with permanent housing and accessible mental health treatment services, they are likely to avoid unstable housing patterns associated with higher use of in-patient services (Dickey et al. 1996). Providing support for clients that increases housing stability reduces their need for treatment, and housing stability is associated with lower treatment costs (Dickey et al. 1997). "Research on supportive housing for people who have been hospitalized in psychiatric facilities has repeatedly found that such programs are successful in reducing rates of rehospitalization and in increasing rates of employment." (Novac and Quance 1998, p 14). This is important when we consider an estimate from British Columbia that the direct costs to government of injection drug use are $6,382 per person per year for health care and law enforcement (Millar 1998).

Research undertaken for the Strutton Housing Association, a provider of housing services for people with HIV in the UK, showed that well-designed housing and a supported housing management services could reduce the need for acute and domiciliary care services and achieve an average of 40 per cent savings in the cost of care for tenants. When compared with the capital investment and housing management services, this became cost effective over five years (Molyneux and Palmer n.d.).

3 Homelessness and Social Services

3.1 Relationship between Homelessness and socio-economic Issues

The literature reports that homelessness is associated with a variety of social problems, most notably family breakdown and abuse, adverse childhood experiences, foster care, youth pregnancy and inadequate parenting skills, and child development problems. In some cases, the social problem is a cause of homelessness. Other times, homelessness creates the problem.

Family Breakdown and Abuse

Domestic abuse is often raised as one of the causes of homelessness (together with lack of low-income housing and insufficient income) (Davey 1998 and Williams 1998). There is also evidence that violence against women and children by husbands and fathers is an increasing factor in homelessness (Novac et al. 1996). In Canada, it was estimated that 16 per cent of the homeless were female victims of domestic abuse in 1987 (Novac et al. 1996). A study in Toronto showed that from 1993 to 1996, spousal abuse, as a reason for admittance into hostels, increased from 6.5 per cent to 10 per cent. In 1996, more than 8,000 women and children used a women's shelter or hostel in Toronto because of spousal abuse or family breakdown (Golden 1999).

Family breakdown and abuse is also a main contributor to youth homelessness (Golden 1999). A Toronto study done by the Addiction Research Foundation in 1992 found that 70 per cent of young people leave home for the streets because of physical and/or sexual abuse. These numbers are consistent with other research studies as well. Studies have found high rates of childhood sexual and physical abuse among homeless adults (Novac et al. 1996). A study of nearly 500 homeless youth in Toronto and Vancouver found that while the children came from all classes, most are from families where physical abuse exacerbated by long-term unemployment and sometimes by parental drug and alcohol abuse is the norm. Most (87 per cent) reported that their parents or guardians used physical discipline in the home, and more than half (60 per cent) indicated that on at least one occasion, they had been hit with enough force to cause a bruise or bleeding (Hagan and McCarthy 1997).

Once they are on the streets, homeless youth are faced with the challenges of finding food, clothing and shelter. They are often unable to find employment and turn to prostitution as a source of income.

Abuse also appears to be a significant factor in the dramatic increase in homeless youth and families with children among the Aboriginal population of Toronto. It is suggested that the legacy of abuse and negative experiences from residential schools has continued, with high levels of family violence and sexual abuse (Golden 1999). Many homeless Aboriginal

people suffer from alcohol and drug abuse, mental illness, sexual abuse, unemployment, and lack of education.

Adverse Childhood Experiences as a Risk Factor in Homelessness

There is evidence that adverse childhood experiences are powerful risk factors for homelessness (Herman et al. 1997). Interviews conducted with a nationally representative sample of 92 United States household members who had previously been homeless, and a comparison group of 395 individuals with no prior homelessness found that lack of care from a parent during childhood sharply increased the likelihood of subsequent homelessness as did physical abuse. The risk of subsequent homelessness among individuals who experienced both lack of care and either physical or sexual abuse was dramatically increased compared with subjects reporting neither of these adversities. Effectively reducing child abuse and neglect may ultimately help prevent critical social problems including homelessness.

Prevalence of Adverse Childhood Experiences (weighted percentages) by adult homelessness: 1994 Follow-up to the Comprehensive Nationwide Study of Knowledge, Attitudes and Beliefs about Homelessness (n=487)

Type of Adversity	Ever homeless per cent	Never Homeless per cent	Total Sample
Lack of care	66	13	16
Physical abuse	48	6	7
Sexual abuse	15	9	10
Lack of care plus either type of abuse	54	5	7
Any childhood adversity	69	22	24

Source: Herman et al. 1997.

A study of 200 homeless youth in London, England and Sydney, Australia also paints a clear picture those family problems were a major contributor to homelessness (Downing-Orr 1996). The majority of youth came from families that were dysfunctional or problematic in some way. Many of the young people indicated that they suffered from poor self-esteem and feelings of worthlessness. They did not feel loved, wanted, or accepted by their parents. With the majority of respondents, homelessness was a process that began during childhood.

Half the respondents in London, and two-thirds in Sydney, had moved frequently during their childhood. They lived in at least four different homes. Financial hardships also contributed to family tensions, hostility and conflict. Most of the children (59 per cent in London and 65 per cent in Sydney) had experienced the divorce of their parents. Often this meant

major disruptive changes that involved placements in public institutions, new stepparents and family regrouping, living with other relatives, and increased financial problems. Many of the young people came from homes where parents behaved aggressively and sometimes violently with each other.

About half the respondents indicated that they had a good or satisfactory relationship with their mother, but in most cases, this was short-lived, and in many instances, a change in family structure (e.g. a new partner) led to problems. The other half described their relationships as confrontational, aggressive, hostile or neglectful. More than half the respondents (53 per cent) described their relationship with their fathers as hostile or estranged. An additional 18 per cent never knew their fathers. About half the respondents were raised by a stepparent, sometimes by several. The vast majority of respondents viewed the relationship with the stepparent as hostile. As many as 70 per cent of the respondents did not feel loved by their parents during childhood. Rather, hostiliity, conflict, and brutality characterized relationships with parents. (Downing-Orr 1996).

Homelessness and Foster Care

Several studies have made a connection between homelessness and involvement in the child welfare system (Child Welfare League of America 1990; Cohen-Schlanger et al. 1995; Roman and Wolfe 1997; Chand et al. 1997; and Downing-Orr 1996). Two types of connections are identified. Previous foster care history is shown to be linked with later homelessness, and children of homeless families are found to be more likely to end up in care. Little research on this relationship has been conducted in Canada. The work cited here is primarily American, although a few British and Australian studies are on topic. It is not clear from the literature if the connection between the child protection system and homelessness evident elsewhere is a factor in Canada.

Studies show that there is an over-representation of people with a foster care history among the homeless population (Roman and Wolfe 1997). An American study with data collected from 21 service organizations located in every region of the United States on 1,134 individuals found that 36.2 per cent of the homeless persons had a foster care history. Of the parents with a foster care history, 77 per cent had at least one child who had been or currently was in foster care. In comparison, 27 per cent of the parents without a foster care history had at least one child who had been or currently was in foster care (Roman and Wolfe 1997).

A study of homeless youth in London, England and Sydney, Australia found that as many as 47 per cent of the London youth and 39 per cent of youth in Sydney had been placed in care at some point during childhood. The most common reason for entering care was problems with parents. These placements were not with foster families but in institutional living arrangements (Downing-Orr 1996).

In addition, childhood placement in foster care correlates with a substantial increase in the length of a person's homeless experience, increased tendency for homeless people to have their own children in foster care, and a likelihood that they will become homeless at an earlier age than people who have not been in foster care. And, people who are homeless frequently have had multiple placements as children, both in foster care and in the homes of families and friends. Numerous reasons have been cited for the connection between foster care and homelessness (Roman and Wolfe 1997, Downing-Orr 1996 and Zlotnick et al. 1998).

- The foster care system often fails to provide children with any type of therapy to help them address the problems that brought them into the system in the first place, (e.g. sexual and physical abuse, family dissolution, parents' alcohol and substance abuse, and being abandoned or orphaned), as well as their own behavioural problems.
- Foster care placements can themselves be abusive situations — several respondents were sexually and physically abused in their foster families.
- Multiple placements can preclude the development of the nurturing bonds that have been shown to be critical to normal personal development.
- Moving children from placement to placement seems to exacerbate the inability of the foster care system to provide them with consistent treatment for their mental or physical health problems.

In addition, today's homeless families are seeing their children placed in care for various reasons. Children's Aid Societies in Toronto have reported that parents who cannot find housing are increasingly asking that their children be placed in foster care (Begin 1996, Cohen-Schlanger et al. 1995). A survey of family services workers at the Children's Aid Society of Metropolitan Toronto (CAS) found that in 18.4 per cent of the cases the family's housing situation was one of the factors that resulted in temporary placement of a child into care. Another Toronto study found that of the homeless women who had a live birth, only 31 per cent still had custody of the child at the time of the study (Kushner 1998). This is also the case in the U.S. A study of African American children in foster care in five major United States cities found that in one-third of the cases inadequate housing or homelessness was the main factor leading to foster care placement (Nelson 1992).

A lack of accessible or affordable permanent housing is also a factor in delaying the return of children to their families (Child Welfare League of America 1990, Nelson 1992 and Cohen-Schlanger et al. 1995). The Toronto study found that in 8.6 per cent of the cases, the return home of a child was delayed due to a housing-related problem. Family service workers must satisfy the CAS and the courts that the family has appropriate accommodation for the child when they are developing plans to return a child to the family. The CAS rarely returns a child to a family that is homeless, living in a temporary hostel or without permanent accommodation. Therefore, although housing is not one of the criteria for a legal assessment of a child's need of protection precipitating admission

into care, it becomes a necessary requirement for families when the CAS is working toward returning children from care (Cohen-Schlanger et al 1995).

Pregnancy and Parenting in Homeless Families

There is a strong relationship between pregnancy and homelessness. As noted earlier, homeless women have high rates of pregnancy. This means that a whole new generation of children will start their lives as part of the homeless population (Golden 1999).

In addition, early childbearing increases risks of homelessness (Hausman and Hammen 1993). In some cases, the heightened stress of caring for a newborn while living in an overcrowded or shared living situation forces women on to the streets (Bassuk and Weinreb 1993).

Parenting while being homeless is a major challenge. Many homeless women are young, have never established an independent household, lack supports and role models, and have limited child-rearing knowledge and skills (Bassiuk and Weinreb 1993 p. 353). It is also difficult to care for a baby in an emergency shelter or on the streets. Welfare hotels often do not have proper cooking facilities or refrigeration, making it difficult to sterilize bottles or refrigerate medication. Living in one room with a newborn is stressful for all members of the family, who are often deprived of sleep. It is also difficult to keep medical appointments because of lack of transportation and lack of childcare for the other children. One of the greatest difficulties faced by mothers is their feeling of incompetence and isolation. Looking after a fussy or needy baby can be overwhelming, particularly for mothers who are isolated and "burdened with the day-to-day tasks of survival." (Bassuk and Weinreb 1993 p. 353).

Many of the factors that contribute to family homelessness may impair parental functioning. The experience of homelessness may erode the ability of parents to provide protection and support and to respond to their children's needs. These struggles may have immediate and long-term consequences for homeless children's development and affect their future capacity to function effectively as parents and productively as members of society (Hausman and Hammen 1993).

Child Development

Studies have shown that homeless children suffer from developmental lags compared to other children in terms of language development, fine motor coordination, gross motor skills, and personal/social development (Bassuk and Gallagher 1990). They are also more likely than the general population to experience learning difficulties and higher rates of mental health problems (e.g. behavioural problems such as sleep disturbance, eating problems, aggression and overactivity); and emotional problems such as depression, anxiety and self-harm (Vostanis 1998).

One study of 80 homeless families with 151 children living in family shelters in Massachusetts found that the school-aged children were severely anxious and depressed. About one third required psychiatric referral and evaluation. School attendance tended to be irregular. Forty-three per cent of children had already repeated a grade, 25 per cent were in special classes, and almost 50 per cent were currently failing or doing below average work in school. It was noted that many of the children were experiencing difficulties when they arrived at the shelters, but living in the shelter made matters worse (Bassuk and Gallagher 1990).

Another study of 52 elementary school-aged children living in a shelter in Central Florida conducted in 1993 and 1994 found that 64 per cent of the homeless children had experienced a sufficient number of stressful events during the three months before coming to the shelter to place them at risk for behavioural difficulties. Both boys and girls scored high on the impulsive categories, which is typified by behaviour that is defiant, impulsive, detached, demanding, uncooperative, withdrawn, aggressive, and prone to fighting. Such children are likely to experience frequent temper outbursts, will pick on other children, and show little interest in schoolwork. Two-thirds of children scored in the clinical range and another 30 per cent scored in the borderline range. The study also showed that homeless children are involved in significantly fewer social activities and organizations, have fewer friends, and perform below average in school (Davey 1998). The consequences are significant as children who chronically experience frustration and conflict in meeting their basic needs are at a high risk for psychopathology. Children with low self-esteem are vulnerable to developing stress disorders (Davey 1998).

However, there is also evidence that these problems are not specific to homeless families. They occur in other families living in difficult conditions and have been found to be related to events that precipitate homelessness e.g. family breakdown, abuse, exposure to domestic violence, and poor social networks (Vostanis 1998). An analysis of school experiences of 169 homeless elementary school students in Wisconsin found that there was not much difference between homeless and low-income children in terms of academic and psychological functioning. About one-third were above grade level; almost two-thirds were below grade level. However, taken together, the children's scores differed substantially from the norm. Findings imply that although homelessness is a stressful event in children's lives, long-term poverty may be a more appropriate marker of risk in children (Zeisemer et al. 1994). It should also be noted that differences have been found between children younger than 18 months and older children, with the younger ones performing significantly higher than the older children on various tests, suggesting that the cumulative effects of childhood poverty may increase with time (Coll et al. 1998).

Finally, a recent study in Massachusetts of 80 homeless children and 148 children age 6 and over who had never been homeless was undertaken to determine whether homelessness has an independent effect on the behavioural and mental health status of school-aged children, controlling for other explanatory factors. The primary focus was to examine the relationship between housing status (homeless vs. housed) and measures of child behaviour and self-reported symptoms of depression and anxiety. Homeless children self-reported higher levels of depressive symptoms and anxiety than their housed counterparts, but these differences were not statistically significant (Buchner et al. 1999).

It has also been noted that the high level of domestic abuse in families can result in long-term consequences for children. In Toronto, it was estimated that 40 to 80 per cent of children who come to a shelter with their mother have witnessed violence in the home (Golden 1999). These children are at increased risk of behavioural and development problems and being involved in future violence. They require special support and services to ensure that violence is not perpetuated in the next generation (Golden 1999).

Although the literature reports on the current social, educational and developmental problems facing homeless and low-income children, there was little information about long-term effects of homelessness. This is likely due to the relatively recent appearance of families with children among the ranks of the homeless.

3.2 Use of Social Services by the Homeless

A variety of different services in different communities are available to address homelessness. Often, services are delivered on a local basis by non-profit agencies, municipalities and other service providers. The variety of services has not generally been documented in the published literature, with the exception of the recent Golden Task Force report (Golden et al. 1999). This report, as well as some of the background papers, describes the range of services available to the homeless in Toronto, from emergency services (including hostels, drop-in centres, foodbanks and outreach services), to supportive housing, and programs designed to help prevent homelessness. Income support and child welfare programs are also part of the socio-economic framework. Only two provinces in Canada, British Columbia and Quebec, are currently funding the development of more social housing, and there is no federal funding for new social housing.

Income Assistance

A relatively high proportion of homeless people do not receive income assistance benefits (CCSD as reported in Begin 1996). Of those included in the survey of people seeking shelter in Canada on January 22, 1987, only 52 per cent were receiving social assistance. This is consistent with a recent study of homeless adults in Los Angeles that found about 58 per cent received government financial assistance in the 30 days prior to the

interview, while one-third had received cash assistance from a family member or friend ($10–$200 US). It was not clear why such a high proportion of the homeless did not participate in government assistance programs, although it was found that transaction costs associated with applying and re-applying for benefits were likely to be an important factor (Schoeni and Koegel 1998). Begin (1996) notes that the lack of an address makes it difficult for homeless people to access government assistance, and without such assistance, a homeless person cannot obtain housing. Studies of homeless youth in Vancouver in 1993 found that between 55 per cent and 66 per cent were receiving social assistance (McCreary Centre Society 1994 and McCarthy 1995). However, a study of 124 emergency shelter users in Vancouver in 1993 found that the majority (82 per cent) were in receipt of public assistance (Acorn 1993).

The need for adequate income support is seen as a key factor in addressing homelessness. There is evidence that homelessness problems in Toronto became more acute when the Ontario government cut social assistance payments by 21.6 per cent (Begin 1996, Golden 1999). In January 1996, the number of households evicted from their rental units was 25 per cent greater than in the previous year. During the early 1990s, after welfare payments were reduced in Calgary, 55 per cent of recipients were reported to be facing eviction (Canadian Public Health Association 1997).

Emergency Services

Emergency shelters are available in most communities, although some communities rely on them more than others as a way to address emergency housing needs. In 1996, almost 26,000 different individuals used the shelter system in Toronto and approximately 3,200 different people used them on any given night (Golden 1999). Families accounted for 46 per cent of hostel users in 1996. Youth under 18, and families with children are the fastest-growing populations using the Toronto hostels. The number of families admitted to hostels increased 76 per cent from 1988 to 1996. In total, 170,000 different people used shelters over that nine year period. A high percentage of hostel users (17 per cent) stayed in the hostel system for a year or more. They are considered "chronic hostel users." Concerns have been expressed that hostels in Toronto have become more than short-term emergency housing. They are being used to fill the gap resulting from the shortage of supportive and low-cost housing (Golden 1999 p. 41). Concerns have also been expressed that the institutional nature of hostels perpetuates homelessness as people lose their independence and ability to manage on their own (Golden 1999).

Drop-in centres are also available to homeless people (e.g. Toronto and Vancouver). There are 27 drop-in centres in Toronto, and they are able to serve 3,800 individuals at any one time (Golden 1999). Drop-in centres provide outreach services to homeless people to help them find or maintain housing.

Foodbanks are also available in nearly 500 communities across Canada, and there is evidence of increasing use. According to a survey conducted by the Canadian Association of Food Banks in 1998, an estimated 3 million people in Canada used food banks in the previous year, which was more than twice the number who used the service in 1989. More than 700,000 people in Canada used food banks in March 1998, up 5.4 per cent compared to the same month in the previous year. The increase may be higher in some centres, for example, during the same period, the use of food banks jumped 17 per cent in the Greater Toronto area and 10 per cent in Niagara Falls (Toronto Star 1998).

Housing Support

Shelter allowances, in one form or another, are being used in the United States and United Kingdom. They also exist in four Canadian provinces — British Columbia, Manitoba, Quebec and New Brunswick (Golden et al. 1999). These are being recommended in the Golden Task Force report as a prevention strategy to help households maintain their housing.

Housing Help Centres provide information on how to undertake a housing search, tenants rights and responsibilities, and other assistance to help people find housing, primarily low-cost units in the private market.

Rent banks and landlord-tenant mediation are tools that have been effective in helping to prevent households from being evicted (Golden 1999 and Begin 1996). Rent bank programs have been operating in the U.S. for several years. The Connecticut Eviction Prevention Program has been operating since 1989 and the state estimates that it has saved about $13 million from the reduced use of hostels over a five year period (Golden 1999).

Legal assistance can also help to reduce evictions as tenants are put on a more equal footing with landlords. Tenants may be able to secure more time in which to deal with arrears or find a new apartment. Assistance may also include referring tenants to mediation or credit counseling to deal with underlying problems.

Individual Support

Individual support may be provided by a variety of different health and socio-economic agencies, including drop-in centres and hospitals that have staff responsible for helping people find and retain stable housing. Some people require support only in the crisis stage; others need ongoing support to remain housed. Housing support implies a less formal arrangement with more emphasis on community development (Golden et al. 1999). Case managers and individual support workers assist homeless people on a one-on-one basis and in informal settings. They help clients respond to crises, help facilitate access to supports and services, and generally assist people with managing daily life. There are an estimated 186 case managers in Toronto and a number of support workers whose clients have mental health and addiction problems. They work out of several different organizations including the Centre for Addiction and Mental Health (CAMH), Community Occupational Therapists and

Associates (COTA), the Hostels Outreach Program (HOP), and multi-service agencies and drop-ins (Golden et al. 1999).

Outreach services are available to help people survive on the streets or help them get off the streets. Outreach workers help homeless people access basic supports and services, including health care services. Some are organized by funded organizations and others are run by volunteers (Golden 1999).

Employment Skills and Training

Programs also exist to help low-income households and social assistance recipients develop the necessary skills for employment and create their own business opportunities. Human Resources Development Canada funds several programs to help low-income people become employed or stay employed. None of these are specifically targeted to homeless people, although the potential exists to use funds for that purpose.

Supportive Housing

Supportive housing provides both housing and support services. It is targeted to specific groups who are vulnerable to becoming homeless or remaining homeless because of their particular circumstances. These could include frail elderly people, teen mothers, women and youth leaving violent or unstable family relationships, people with mental illness, addictions, HIV/AIDS, or those who have been discharged from institutions such as psychiatric hospitals or jails. "Research in Canada and the United States shows that supportive housing is an appropriate and effective response to homelessness." (Golden 1999 p. 121). "A major study of 900 homeless adults with mental illness in three American cities found that nearly all those who lived in supportive housing projects stayed housed and increased their use of community-based mental health treatment and other services." (p. 122). There is a range of different types of supportive housing including group homes, supervised apartments, housing with independent supports, and mobile community supports.

Social Housing

Much has been written on the types of social programs that are necessary to combat homelessness. Subsidized housing is seen as the primary predictor of housing stability among formerly homeless families, and is critical to ending homelessness among families (Shinn 1998). A longitudinal study of 564 homeless families in New York City supports the view that for families, homelessness is a temporary state that is resolved by the provision of subsidized housing (Shinn 1997). Other studies suggest that additional support services are necessary. For example, a study of 58 formerly homeless, now housed families with 103 children and 21 comparison families of low socio-economic status in stable housing with 54 children, found that rehoused mothers and their children had significantly higher mental health problems than mothers and children in the comparison group. In contrast with the comparison group of families of low socio-economic status, a substantial proportion of formerly homeless

families remained residentially and socially unstable (Vostanis 1998). Other reports have stressed the need for more preventive social programs to foster stronger relationships between parents and children, help families stay together, and prevent evictions.

3.3 Costs of Homelessness for the Social Services System

Very little published information was found which estimates or calculates the costs of various socio-economic responses to homelessness, or attempts to compare the costs and benefits of these approaches. The Golden Task Force commissioned the only such study as part of its background research (Pomeroy and Dunning, 1998). The purpose of this study was to determine the cost-effectiveness of different housing and support options for the homeless in Toronto, ranging from psychiatric hospitals to rooming houses.

As part of their cost-benefit analysis, Pomeroy and Dunning prepared separate estimates of housing costs and support service costs associated with a range of different types of housing alternatives. Based on this analysis, Golden concludes:

> "Not only are shelters inappropriate places for chronically homeless people, they are expensive. Our research has shown that supportive housing is more cost-effective than housing people in shelters and other institutions. For example, a supportive housing unit with medium support costs in the range of $30 to $40 a day compared to an average of $38 a day for shelters, $360 a day for psychiatric hospitals, and $124 a day for prisons and detention centres." (p. 122).

This is similar to 1995 estimates from a group called Almost Home in New York City, a coalition of business people who advocate support housing. They estimate that:

- a permanent home and supportive services costs $12,500 US a year ($34/US day);
- a shelter cot costs $20,000 US a year ($55/US day);
- a psychiatric hospital bed costs $113,000 US a year ($310/US day); and
- a prison cell costs $60,000 US a year ($164/US day).

This group believes that "combining affordable housing with appropriate services, including help in finding work has consistently succeeded in helping people get off the streets and rebuild their lives. Supportive housing is not only more effective, it is far less expensive than traditional responses to homelessness. Shelters, hospitalization and legal interventions consume our tax dollars without permanently reducing homelessness." (Daly 1996 p.150).

Another study from Britain also supports the view that the long term cost of keeping families in temporary accommodation, such as bed and breakfast hotels, is more expensive than providing permanent housing (Burrows and Walentowicz 1992).

There is some evidence that increasing numbers of families are relying on emergency resources for housing, leading to an increase in costs to the system. In February 1996, an article in the Globe and Mail reported a 45 per cent increase since 1995 in the number of families in Metro Toronto seeking emergency refuge. It was necessary to place over 1000 people, 600 of them children, in motels as a result of insufficient shelter space. Many of these families had been evicted from their apartments, "a situation that was attributed to the 21.6 per cent reduction in welfare payments." (Begin 1996). This is an expensive solution. It is estimated that maintaining families in motels costs twice as much as providing families with social assistance to enable them to live in an apartment. Metro's budget for hostel services was expected to increase by $8.5 million in 1996 to $53.2 million in response to the need to provide emergency shelter (Begin 1996).

There are also costs associated with the child welfare system. It has been reported that the costs of taking children into care is very high. In Canada, 1992 data estimated that it costs an average of $23,000 per child, assuming that an average month in care costs $1,528 per child and children spend an average of 15 months in temporary care (Cohen-Schlanger et al. 1995). A 1991 United States study by the Child Welfare League of America estimated that for every child returned home from foster care or not placed in foster care, there would be potential annual savings of between $6,000 and $10,000 US per child (Nelson 1992).

These costs do not include the social and emotional impacts of a child being placed in out-of-home-care. A great deal of research demonstrates the negative consequences of removing children from their parents. The study concludes that access to safe and affordable housing will not necessarily prevent child admissions to CAS care, but housing support may reduce the number of admissions, stabilize the family's living situation in ways that promote children's well-being, and reduce housing-related delays in the return of children to their homes.

4 Homelessness and Criminal Justice

Most of the literature on crime and homelessness suggest that crime is inevitable among those who live on the street. In addition, the potential for such crime is more likely if one has been homeless for an extended period of time or if one is mentally ill (Hewitt 1994).

4.1 Homelessness and the use of the Criminal Justice System

According to Hewitt (1994), there is little Canadian literature on the relationships between homelessness, crime and the criminal justice system. Only two studies were located which refer specifically to the B.C. context (Zapf 1996; Hagan and McCarthy 1997). However, studies of homeless people in the United States have found high rates of arrest and incarceration among the homeless, ranging from 20 per cent to 67 per cent. This compares to the rates of arrest in the general population of 22 per cent for men and 6 per cent for women (Fischer 1992).

A common way of gauging the relationship is to investigate the housing history of the prison population. In one United States study, data from three cross-sectional samples of inmates in the New York City correctional system were analyzed to determine the prevalence of homelessness among detainees. It found that between 24 per cent and 34 per cent of each sample had been homeless at some time during the two months prior to arrest and 22 per cent of the primary sample had been homeless the night before arrest (Michaels et al. 1992).

Prevalence of homelessness among three samples of New York City jail inmates

	Sample 1 (n=299)			Sample 2 (n=236)	Sample 3 (n=151)
	Ever homeless in last three years	Last two months	Night before arrest	Last two months	Last two months
Total	40 per cent	27 per cent	22 per cent	24 per cent	34 per cent

Source: Michaels et al. 1992

A study in the province of Quebec found that homeless persons occupied about 5.5 per cent of the normal capacity of detention centres (171 places out of 3,115). Most of these homeless people were in detention centres in Montreal and Quebec City (Dallaire 1992).

Vitelli (1993), in a study of Canadian inmates, found a significant difference between those who were homeless and domiciled, in terms of previous criminal history: 80 per cent of those who were formerly homeless had previous convictions compared to 64 per cent of those who were domiciled. Another Canadian study, this time of the population in a pre-trial facility in Vancouver, found that formerly homeless individuals were significantly more likely to have had a juvenile criminal history (64 per cent) than domiciled persons (50 per

cent). Homeless individuals were more likely to have an adult criminal record (93 per cent) than those who were not homeless (82 per cent) (Zapf 1996).

Four different explanations have been identified for criminal activity among the homeless (Hewitt 1994 and Fischer 1992). First, for many homeless people, criminal activity may be one of the only ways to survive. It is difficult for them to find employment, and yet substantial proportions do not benefit from public support programs, including income assistance. Many resort to petty pilfering, shoplifting, small-scale drug dealing, nonpayment of cab fares and restaurant tabs, and prostitution. It has been suggested that criminal activity of this sort could be reduced if more homeless people were part of the social services safety net. Second, there are the habitual criminals who may suffer from chronic deviant behaviour, antisocial personalities and drug disorders. Third, there is evidence of homeless people who manipulate police into making an arrest in order to obtain "temporary asylum" in jail. This has been labeled "functionally adaptive criminal behaviour." Fourth, there are the homeless who display inappropriate or bizarre behaviour that lands them in a correctional institution rather than in more appropriate systems of socio-economic treatment or institutionalization. "Psychotic behaviour — sometimes violent — or disorientation associated with intoxication, mental illness, and mental retardation may call the police into play." (Fischer 1992 p. 104). Literature from Quebec points out that activities that are associated with homelessness, such as loitering, noise and panhandling, which contravene municipal bylaws, often bring homeless people into contact with the police and the justice system (Laberge and Morin 1997).

There is no Canada-wide information on the number or percentage of people in correctional institutions that are homeless. Literature out of Quebec suggests that homelessness complicates standard criminal justice system processes and may mean that once charged with a criminal activity, homeless people are more likely to be held than domiciled persons. Once brought into the justice system, a person's homelessness may then play a role in subsequent decision making. Some conditions under which people may be held before a trial are more likely to apply to homeless people, e.g. if there is concern that the person will not appear in court for the day they are summoned. The court system may also require persons to keep the peace while they are awaiting their court appearance, which can be difficult for homeless people who are often perceived as disturbing the peace. Another issue is that people who are found guilty are often required to pay a fine, which is based on the nature of the crime rather than on ability to pay. If the person cannot pay, they are sentenced to prison. Homeless people often find themselves in this situation. Probation periods require the person to maintain contact with an officer, which is also difficult for many homeless people (Laberge and Morin 1997).

It has been estimated that 30 per cent of those incarcerated will have no homes to go to upon their release (Kushner 1998). Research from Toronto showed that over nine years (1987–1996) 2.2 per cent of people using shelters came from the corrections system. However, they tended to be among the most "chronic" shelter users, with a 30 per cent chance of remaining in the shelters for one year or more (Springer et al. 1998).

This review of the literature was unable to locate any studies of the relationships between homelessness and other aspects of the criminal justice system, for example, the impacts on police or the courts. There is evidence that specific sub-groups of the homeless have more involvement with the criminal justice system or a certain type of involvement with the system.

4.2 Homelessness, Mental Illness and the Criminal Justice System

Homelessness and mental illness together are strong predictors of involvement with the correctional system according to both U.S. and Canadian literature. Mentally ill persons who are homeless are particularly vulnerable to frequent involvement with the criminal justice system (Gelberg et al. 1988, Belcher 1988 and Landreville et al. 1998). Several surveys (including two Canadian studies) have shown that among homeless people, those who report psychiatric illness or hospitalization are most likely to have a history of arrest or incarceration (Michaels 1992, Vitelli 1993 and Zapf 1996). A community-based survey of 529 homeless adults in Los Angeles County found that homeless persons who had previous psychiatric hospitalizations had the worst mental health status, used alcohol and drugs the most, and were the most involved in criminal activities. Seventy-six per cent of these persons reported a previous arrest. At least 46 per cent of the rest of the sample had also been arrested (Gelberg et al. 1988). In the New York study, further analysis found that 50 per cent of those who had been homeless during the past three years responded positively to at least one mental illness screening question, compared with 25 per cent of the never-homeless inmates. More than 33 per cent of those who had been homeless in the previous three years had received mental health treatment, compared with 20 per cent of these who had never been homeless (Michaels et al. 1992).

Canadian studies have also found a strong relationship between homelessness, mental illness and crime. One study of maximum security inmates in Millbrook Correctional Centre, Peterborough Ontario found that 51 per cent of homeless inmates displayed obvious psychiatric symptoms upon admission to the correctional centre compared to 18 per cent of domiciled inmates (Vitelli 1993). Another study of a Vancouver pretrial facility also found that a significantly larger proportion of homeless individuals in the pretrial facility (36 per cent) were severely mentally disordered compared to domiciled individuals (17 per cent) (Zapf et al. 1996). The following table summarizes the existing data.

Variable	Homeless Inmates	Domiciled Inmates	Study location and author
Mental illness	50 per cent	25 per cent	United States — Michaels 1992
Mental health treatment	33 per cent	20 per cent	United States — Michaels 1992
Psychiatric symptoms	51 per cent	18 per cent	Canada — Vitelli 1993
Mentally disordered	36 per cent	17 per cent	Canada — Zapf 1996

4.3 Homelessness, Youth, and the Criminal Justice System

A study of street youth between the ages of 15 and 24 in Toronto and Vancouver found that they spent most of their time foraging for food, shelter and money, and hanging out with other street youth in parks, shopping malls and social agencies. The more difficult it was for them to find food and shelter, the more likely it was that they would turn to crime (Hagan and McCarthy 1997). The longer these youth are on the street, the more exposure they have to criminal activity and encounters with the police. Theft of food and clothing, (what might be called survival crime) escalates into more serious crime. Another significant finding was that law and order responses tended to create the exact reverse of their intended effect. Police responses may further stigmatize victims of abuse, encouraging defiant and persistent involvement in street crime.

Hagan and McCarthy also report that street youth are more likely to engage in criminal activity than their housed counterparts. In addition, although they are a relatively small proportion of all adolescents, street youth are involved in a substantial and disproportionate amount of all crime. Street youth are also disproportionately repeat offenders.

The following table illustrates the extent and nature of youth crime.

Involvement in crime	Location of study and source
◆ 33 per cent of runaways admitted stealing after leaving home ◆ 15 per cent admitted stealing objects worth $50 or more ◆ 20 per cent reported selling drugs	Colorado — Brennan et al. 1978 as cited in Hagan and McCarthy 1997
◆ 71 per cent of runaways reported being encouraged by others to participate in crime while on the street ◆ 49 per cent admitted involvement in unspecified illegal activities	Edmonton — Kufeldt and Nimmo 1987 as cited in Hagan and McCarthy 1997
◆ 43 per cent of homeless youth shoplifted on the street ◆ 33 per cent sold drugs ◆ 32 per cent committed break and enter ◆ 9 per cent worked in prostitution	Midwestern U.S. — Whitbeck and Simons 1990, 1993 as cited in Hagan and McCarthy 1997
◆ 46 per cent of homeless respondents made drug sales ◆ 49 per cent stole goods valued up to $50 ◆ 27 per cent broke into homes or business	Toronto — McCarthy and Hagan 1991 as cited in Hagan and McCarthy 1997
◆ 100 per cent of the 200 study participants had been involved in some criminal activity—an average of 2.7 different types per respondent. Shoplifting was most common, especially among the younger street youth. Drug-related crimes tended to be carried by older (over 18) youth. Younger people appeared to graduate to break and enter.	Nova Scotia — reported by National Crime Prevention Centre 1997
◆ 46 per cent of respondents reported committing crime after they became homeless. Nature of activity included theft (63 per cent), violent offences (21 per cent), property destruction (9 per cent), and drugs (7 per cent)	London — Downing-Orr 1996
◆ 72 per cent of respondents reported committing crime after they became homeless. Nature of activity include theft (48 per cent), violent offences (31 per cent), drugs (14 per cent), and property destruction (7 per cent)	Sydney — Downing-Orr 1996

There is evidence that many street youth are headed toward street crime before they leave home (Hagan and McCarthy 1997, Downing-Orr 1996). A study of homeless youth in London and Sydney found that a high percentage of respondents (50 per cent in London and 70 per cent in Sydney) were involved in crime before they became homeless. Study participants reported that they first started committing crime as a way of signaling for help due to family problems (e.g. abuse). In other cases, respondents turned to crime as a way to gain acceptance by other youths. On average, respondents committed their first crime at the age of 13. About the same number of young people continued to commit crime after

they became homeless. The main reasons given for this were to obtain money, and for the "thrill" — a way to relieve boredom. The vast majority were also taking drugs as a means of escape and for comfort. Through exposure to professional criminals, youth learned how to commit more serious crimes.

Evidence about street youth found that a "social welfare model" which is more focussed on providing youth with access to shelters and other support services provides reduced opportunities to become involved in crime. Another important finding is that the most effective way for youth to "beat the street" is through employment. Those youth who managed to find a job were better housed and fed, and more able to distance themselves from the criminogenic environment of the street (Ogrady 1998).

4.4 Types of Criminal Activity Among the Homeless

A fair amount has been written about criminal activity undertaken by homeless youth, but little has been reported on the nature of the criminal activity among the rest of the homeless (Fischer 1992). While there is evidence that homeless individuals are more likely to commit crime than the domiciled, there is considerable debate in the Canadian literature over whether homeless individuals commit more serious crimes than domiciled people (Hewitt 1994). Some evidence suggests that where offences are reported, homeless people are most often arrested for relatively trivial and victimless crimes — arising more from the homeless condition than deliberate criminal intent (Hewitt 1994 and Dallaire 1992). Relatively minor offences are often what draw homeless people to the attention of law enforcement personnel. For example, complaints may be lodged with the police for behaviour that is perceived as unacceptable, such as begging, sleeping on benches, rummaging in garbage, and loitering (Laberge and Morin 1997). In addition, their crimes may be more visible than the domiciled population since they have very limited access to private places for criminal activity (Hewitt 1994 and Dallaire 1992).

Studies in Quebec have found that homeless people are more likely to be involved with the correctional system for crimes against property (e.g. theft, breaking and entry, and fraud) and minor infractions (e.g. misdemeanours, noise, loitering, and drunkenness). Other infractions include drug possession, trafficking, prostitution and non-payment of fines. Most of the crimes relate to alcohol and drug abuse, psychological or psychiatric problems, and social behaviour (Dallaire 1992). One study in Montreal from 1980–1983 found that 372 homeless women were involved in the judicial system. Sixty-four per cent of these cases were as a result of infractions of municipal regulations (noise, loitering, public drunkenness), and 36 per cent were for infractions of the criminal code (e.g. theft, soliciting) (Vallieres and Simon 1998).

A Canadian study of 110 randomly selected inmates at the Millbrook Correctional Centre found significant differences in the types of crimes committed by formerly homeless and domiciled inmates (Vitelli 1993). However, the seriousness of the offences is not clear from this data.

Comparison of offences between homeless and domiciled inmates (43 homeless, 67 domiciled)		
Offence	**Homeless**	**Domiciled**
Sexual Offence	2.3 per cent	37.3 per cent
Property Offence	41.9 per cent	29.9 per cent
Assault	34.9 per cent	16.4 per cent
Drug Offence	0 per cent	3 per cent
Other	20.9 per cent	13.4 per cent

However, the study of 679 participants in a Vancouver pretrial population reported by Zapf (1996) found that there were no significant differences between homelessness and the non-homeless in the types of crimes committed, including violent, property, drug and miscellaneous offences.

4.5 Costs of Homelessness for the Criminal Justice System

The research literature contained no analyses that relate specifically to the financial impact of homelessness on the criminal justice system. There was some data available that compares the costs per person per day of various housing solutions to homelessness in Toronto (Pomeroy and Dunning 1998). It found that use of prison or detention centres as a form of accommodation ranked high in the cost framework, at $124 per day compared to a hostel at $30 to $43 per day and a Habitat contracted boarding house with mental health support at $43 per day. In New York City, it was estimated that a prison cell costs $164 US per day compared to a shelter cot at $55 US per day and a permanent home and supportive services at $34 US per day (Daly 1996).

In 1993/94, spending on police services, the courts, legal aid and corrections was $9.7 billion in Canada. The annual cost of incarcerating an adult is estimated to be between $40,000 and $80,000 per year, and even more for women.[1] The average length of incarceration for adults in federal correctional institutions is 44 months, representing a total cost of between $147,000 and $293,000. The cost of detaining a young offender is at least $100,000, and for every single youth who chronically re-offends, it is estimated that society faces a total cost of at least $200,000 (National Crime Prevention Council 1996a).

[1] The only published information on the costs of incarceration is for federal institutions, while homeless offenders may be more likely to be incarcerated in provincial institutions due to the relatively minor nature of their crimes.

The literature points to a need for alternatives to prevent crimes through social development initiatives, to prevent homeless people from returning to the streets upon their release from jail, and to reduce the incarceration rate among homeless people (International Centre for the Prevention of Crime and National Crime Prevention Council 1996a). Suggestions are also made for links between jail and community services for the homeless (Zapf et al. 1996). Jail services could be a starting point that provides an opportunity to identify the needs of inmates both within the institution and after release. For example, in one pretrial jail project, a full-time social worker employed by a community mental health centre meets with inmates while they are still in jail and then coordinates services for them after their release (Zapf et al. 1996).

There is also a need for stronger links between the mental health system and the legal system to get mentally ill offenders the help they need rather than warehousing them in the prison system (Zapf et al. 1996). Corrections and mental health personnel need to work together in an effort to reduce the revolving door cycle of admissions to both jail and mental health facilities. Given that many homeless adults have an overwhelming set of social, mental health, criminal, alcoho! and drug problems, an effective solution will need to combine the efforts of socio-economic, housing, mental health, and drug and alcohol addition service providers.

5 Conclusions

Relationship Between Homelessness, Health, Social Services, and Criminal Justice

The literature demonstrates that there is a relationship between homelessness and the health care, social services and criminal justice systems. People who do not have safe, secure, affordable shelter have more health problems than the general population, experience social problems that may be exacerbated by their lack of shelter, and are more likely to become involved in criminal activity than the general public. This tends to result in greater use of some services by the homeless, particularly hospital emergency services, shelters and correctional institutions, in terms of frequency and length of use. Some specific sub-groups of the homeless are even more likely to be involved with the health care, social services and criminal justice systems particularly the mentally ill.

Preventive Measures are more Cost-Effective than the Status Quo

There is evidence in the literature that homelessness, like other social problems, is more costly to deal with after the fact, than if it is prevented in the first place. It is essentially a problem of "pay now or pay **more** later." For example, there is a strong connection between homelessness and criminal justice, and the need to support and strengthen families is key in both cases. For many, homelessness is a process that begins during childhood. Youth may be headed toward street crime before they leave home, as criminal activity may be a sign of serious family trouble (e.g. abuse). Efforts to address social problems and social stresses in the family can produce long term benefits, both in terms of crime prevention and reduced homelessness.

The need for decent quality, affordable housing is also critical. Studies indicate that better access to supportive housing is cost-effective and far less expensive than other alternatives such as hospital beds, shelters and jails. "Combining affordable housing with appropriate services including help in finding work has consistently succeeded in helping people get off the streets and rebuild their lives." (Daly 1996). Access to safe and affordable housing could also achieve savings in the child welfare system by helping reduce the number of admissions of children into care and reduce housing-related delays in the return of children to their homes. Measures that can help households maintain their housing would also be beneficial.

Homelessness and Poverty

An important issue that needs to be highlighted is whether homeless people experience problems and use services more than domiciled low-income individuals. Where this question has been addressed in the design of particular studies, the answer often appears to be yes. The lack of housing specifically appears to exacerbate problems associated with low income alone. New York pediatricians familiar with the health of homeless children have identified a "homeless child syndrome" consisting of a number of illnesses and developmental problems that are more common among homeless children than others, even poverty level children.

Growing Interest in the Costs of Homelessness

Interest in estimating the costs of homelessness to government is growing. While few studies were located that dealt specifically with this issue, a number are currently underway (Culhane in the United States and McLaughlin in Toronto). Those studies that have been carried out show that additional costs are incurred to serve homeless individuals compared to others.

Applicability of Findings to British Columbia

While the bulk of the research literature cited here is from the United States and may not be applicable in the Canadian context, a significant amount of research has also been undertaken in Canada. Fewer studies were found that addressed the situation in British Columbia. No empirical research was found that was national in scope. Further research is needed to learn more about homeless people in British Columbia, their needs for services, their use of the health care, social services and criminal justice systems, and policies and programs that affect their use of these services.

Social Costs of Homelessness

This review of the literature did not include studies of the social costs of homelessness, that is, costs both to the homeless individual and to society as a whole. Rather, it concentrated on studies that estimated costs to government, which would tend to underestimate the true cost of homelessness.

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